An act to amend Sections 14132.100, 14197, and 14197.04 of, and to repeal and add Sections 14132.725 and 14132.731 of, the Welfare and Institutions Code, relating to Medi-Cal.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 14132.100 of the Welfare and Institutions Code is amended to read:

14132.100. (a) The federally qualified health center services described in Section 1396d(a)(2)(C) of Title 42 of the United States Code are covered benefits.

(b) The rural health clinic services described in Section 1396d(a)(2)(B) of Title 42 of the United States Code are covered benefits.

(c) Federally qualified health center services and rural health clinic services shall be reimbursed on a per-visit basis in accordance with the definition of "visit" set forth in subdivision (g).

(d) Effective October 1, 2004, and on each October 1 thereafter, until no longer required by federal law, federally qualified health center (FQHC) and rural health clinic (RHC) per-visit rates shall be increased by the Medicare Economic Index applicable to primary care services in the manner provided for in Section 1396a(bb)(3)(A) of Title 42 of the United States Code. Prior to January 1, 2004, FQHC and RHC per-visit rates shall be adjusted by the Medicare Economic Index in accordance with the methodology set forth in the state plan in effect on October 1, 2001.

(e) (1) An FQHC or RHC may apply for an adjustment to its per-visit rate based on a change in the scope of services provided by the FQHC or RHC. Rate changes based on a change in the scope of services provided by an FQHC or RHC shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(2) Subject to the conditions set forth in subparagraphs (A) to (D), inclusive, of paragraph (3), a change in scope of service means any of the following:

(A) The addition of a new FQHC or RHC service that is not incorporated in the baseline prospective payment system (PPS) rate, or a deletion of an FQHC or RHC service that is incorporated in the baseline PPS rate.

(B) A change in service due to amended regulatory requirements or rules.

(C) A change in service resulting from relocating or remodeling an FQHC or RHC.

(D) A change in types of services due to a change in applicable technology and medical practice utilized by the center or clinic.

(E) An increase in service intensity attributable to changes in the types of patients served, including, but not limited to, populations with HIV or AIDS, or other chronic diseases, or homeless, elderly, migrant, or other special populations.

(F) Any changes in any of the services described in subdivision (a) or (b), or in the provider mix of an FQHC or RHC or one of its sites.

(G) Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the services described in subdivision (a) or (b), including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic.

(H) Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents.

(I) Any changes in the scope of a project approved by the federal Health Resources and Services Administration (HRSA).

(3) A change in costs is not, in and of itself, a scope-of-service change, unless all of the following apply:

(A) The increase or decrease in cost is attributable to an increase or decrease in the scope of services defined in subdivisions (a) and (b), as applicable.

(B) The cost is allowable under Medicare reasonable cost principles set forth in Part 413 (commencing with Section 413) of Subchapter B of Chapter 4 of Title 42 of the Code of Federal Regulations, or its successor.

(C) The change in the scope of services is a change in the type, intensity, duration, or amount of services, or any combination thereof.

(D) The net change in the FQHC's or RHC's rate equals or exceeds 1.75 percent for the affected FQHC or RHC site. For FQHCs and RHCs that filed consolidated cost reports for multiple sites to establish the initial prospective payment reimbursement rate, the 1.75-percent threshold shall be applied to the average per-visit rate of all sites for the purposes of calculating the cost associated with a scope-of-service change. "Net change" means the per-visit rate change attributable to the cumulative effect of all increases and decreases for a particular fiscal year.

(4) An FQHC or RHC may submit requests for scope-of-service changes once per fiscal year, only within 90 days following the beginning of the FQHC's or RHC's fiscal year. Any approved increase or decrease in the provider's rate shall be retroactive to the beginning of the FQHC's or RHC's fiscal year in which the request is submitted.

(5) An FQHC or RHC shall submit a scope-of-service rate change request within 90 days of the beginning of any FQHC or RHC fiscal year occurring after the effective date of this section, if, during the FQHC's or RHC's prior fiscal year, the FQHC or RHC experienced a decrease in the scope of services provided that the FQHC or RHC either knew or should have known would have resulted in a significantly lower per-visit rate. If an FQHC or RHC discontinues providing onsite pharmacy or dental services, it shall submit a scope-of-service rate change request within 90 days of the beginning of the following fiscal year. The rate change shall be effective as provided for in paragraph (4). As used in this paragraph, "significantly lower" means an average per-visit rate decrease in excess of 2.5 percent.

(6) Notwithstanding paragraph (4), if the approved scope-of-service change or changes were initially implemented on or after the first day of an FQHC's or RHC's fiscal year ending in calendar year 2001, but before the adoption and issuance of written instructions for applying for a scope-of-service change, the adjusted reimbursement rate for that scope-of-service change shall be made retroactive to the date the scope-of-service change was initially implemented. Scope-of-service changes under this paragraph shall be required to be submitted within the later of 150 days after the adoption and issuance of the written instructions by the department, or 150 days after the end of the FQHC's or RHC's fiscal year ending in 2003.

(7) All references in this subdivision to "fiscal year" shall be construed to be references to the fiscal year of the individual FQHC or RHC, as the case may be.

(f) (1) An FQHC or RHC may request a supplemental payment if extraordinary circumstances beyond the control of the FQHC or RHC occur after December 31, 2001, and PPS payments are insufficient due to these extraordinary circumstances. Supplemental payments arising from extraordinary circumstances under this subdivision

shall be solely and exclusively within the discretion of the department and shall not be subject to subdivision (*l*). These supplemental payments shall be determined separately from the scope-of-service adjustments described in subdivision (e). Extraordinary circumstances include, but are not limited to, acts of nature, changes in applicable requirements in the Health and Safety Code, changes in applicable licensure requirements, and changes in applicable rules or regulations. Mere inflation of costs alone, absent extraordinary circumstances, shall not be grounds for supplemental payment. If an FQHC's or RHC's PPS rate is sufficient to cover its overall costs, including those associated with the extraordinary circumstances, then a supplemental payment is not warranted.

(2) The department shall accept requests for supplemental payment at any time throughout the prospective payment rate year.

(3) Requests for supplemental payments shall be submitted in writing to the department and shall set forth the reasons for the request. Each request shall be accompanied by sufficient documentation to enable the department to act upon the request. Documentation shall include the data necessary to demonstrate that the circumstances for which supplemental payment is requested meet the requirements set forth in this section. Documentation shall include both of the following:

(A) A presentation of data to demonstrate reasons for the FQHC's or RHC's request for a supplemental payment.

(B) Documentation showing the cost implications. The cost impact shall be material and significant, two hundred thousand dollars ($200,000) or 1 percent of a facility's total costs, whichever is less.

(4) A request shall be submitted for each affected year.

(5) Amounts granted for supplemental payment requests shall be paid as lump-sum amounts for those years and not as revised PPS rates, and shall be repaid by the FQHC or RHC to the extent that it is not expended for the specified purposes.

(6) The department shall notify the provider of the department's discretionary decision in writing.

(g) (1) An FQHC or RHC "visit" means a face-to-face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, or a visiting nurse. For purposes of this section, "physician" shall be interpreted in a manner consistent with the federal Centers for Medicare and Medicaid Services' Medicare Rural Health Clinic and Federally Qualified Health Center Manual (Publication 27), or its successor, only to the extent that it defines the professionals whose services are reimbursable on a per-visit basis and not as to the types of services that these professionals may render during these visits and shall include a physician and surgeon, osteopath, podiatrist, dentist, optometrist, and chiropractor. A visit shall also include a face-to-face encounter between an FQHC or RHC patient and a comprehensive perinatal practitioner, as defined in Section 51179.7 of Title 22 of the California Code of Regulations, providing comprehensive perinatal services, a four-hour day of attendance at an adult day health care center, and any other provider identified in the state plan's definition of an FQHC or RHC visit.

(2) (A) A visit shall also include a face-to-face encounter between an FQHC or RHC patient and a dental hygienist, a dental hygienist in alternative practice, or a marriage and family therapist.

(B) Notwithstanding subdivision (e), if an FQHC or RHC that currently includes the cost of the services of a dental hygienist in alternative practice, or a marriage and family therapist for the purposes of establishing its FQHC or RHC rate chooses to bill these services as a separate visit, the FQHC or RHC shall apply for an adjustment to its per-visit rate, and, after the rate adjustment has been approved by the department, shall bill these services as a separate visit. However, multiple encounters with dental professionals or marriage and family therapists that take place on the same day shall constitute a single visit. The department shall develop the appropriate forms to determine which FQHC's or RHC's rates shall be adjusted and to facilitate the calculation of the adjusted rates. An FQHC's or RHC's application for, or the department's approval of, a rate adjustment pursuant to this subparagraph shall not constitute a change in scope of service within the meaning of subdivision (e). An FQHC or RHC that applies for an adjustment to its rate pursuant to this subparagraph may continue to bill for all other FQHC or RHC visits at its existing per-visit rate, subject to reconciliation, until the rate adjustment for visits between an FQHC or RHC patient and a dental hygienist, a dental hygienist in alternative practice, or a marriage and family therapist has been approved. Any approved increase or decrease in the provider's rate shall be made within six months after the date of receipt of the department's rate adjustment forms pursuant to this subparagraph and shall be retroactive to the beginning of the fiscal year in which the FQHC or RHC submits the request, but in no case shall the effective date be earlier than January 1, 2008.

(C) An FQHC or RHC that does not provide dental hygienist, dental hygienist in alternative practice, or marriage and family therapist services, and later elects to add these services and bill these services as a separate visit, shall process the addition of these services as a change in scope of service pursuant to subdivision (e).

(3) Notwithstanding any other provision of this section, no later than July 1, 2018, a visit shall include a marriage and family therapist.

(4) (A) (i) Subject to subparagraph (C), a visit shall also include an encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, visiting nurse, comprehensive perinatal services program practitioner, or marriage and family therapist using video synchronous interaction, when services delivered through that interaction meet the applicable standard of care. A visit described in this clause shall be reimbursed at the applicable FQHC's or RHC's per-visit PPS rate to the extent the department determines that the FQHC or RHC has met all billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter. An FQHC or RHC is not precluded from establishing a new patient relationship through video synchronous interaction. An FQHC patient shall reside within the FQHC's federally designated service area as of the date of service.

(ii) Subject to subparagraph (C), a visit shall also include an encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, visiting nurse, comprehensive perinatal services program practitioner, or marriage and family therapist using audio-only synchronous interaction, when services delivered through that modality meet the applicable standard of care. A visit described in this clause shall be reimbursed at the applicable FQHC's or RHC's per-visit PPS rate to the extent the department determines that the FQHC or RHC has met all billing requirements that

would have applied if the applicable services were delivered via a face-to-face encounter.

(iii) An FQHC or RHC may not establish a new patient relationship using an audio-only synchronous interaction. Notwithstanding this prohibition, the department may provide for specific exceptions to this prohibition, which shall be developed in consultation with affected stakeholders and published in departmental guidance.

(iv) An FQHC or RHC is not precluded from establishing a new patient relationship through an asynchronous store and forward modality, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, if the visit meets all of the following conditions:

(I) The patient is physically present at an originating site that is a licensed or intermittent site of the FQHC or RHC at the time the service is performed.

(II) The individual who creates the patient records at the originating site is an employee of the FQHC or RHC.

(III) The FQHC or RHC determines that the billing provider is able to meet the applicable standard of care.

(IV) For an FQHC new patient relationship, the patient resides within the FQHC's federally designated service area as of the date of service.

(B) (i) Pursuant to an effective date designated by the department that is no sooner than January 1, 2024, an FQHC or RHC furnishing applicable health care services via audio-only synchronous interaction shall also offer those same health care services via video synchronous interaction to preserve beneficiary choice.

(ii) Effective on the date designated by the department pursuant to clause (i), an FQHC or RHC furnishing services through video synchronous interaction or audio-only synchronous interaction shall also do one of the following:

(I) Offer those services via in-person, face-to-face contact.

(II) Arrange for a referral to, and a facilitation of, in-person care that does not require a patient to independently contact a different provider to arrange for that care.

(iii) In addition to any existing law requiring beneficiary consent to telehealth, including, but not limited to, subdivision (b) of Section 2290.5 of the Business and Professions Code, all of the following shall be communicated by an FQHC or RHC to a Medi-Cal beneficiary, in writing or verbally, at least once prior to initiating the delivery of applicable health care services via telehealth to a Medi-Cal beneficiary: an explanation that beneficiaries have the right to access covered services that may be delivered via telehealth through an in-person, face-to-face visit; an explanation that use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time by the Medi-Cal beneficiary without affecting their ability to access covered Medi-Cal services in the future; an explanation of the availability of Medi-Cal coverage for nonmedical transportation services to in-person visits when other available resources have been reasonably exhausted; and the potential limitations or risks related to receiving services through telehealth as compared to an in-person visit, to the extent any limitations or risks are identified by the FQHC or RHC.

(I) The FQHC or RHC shall document in the patient record the provision of this information and the patient's verbal or written acknowledgment that the information was received.

(II) The department shall develop, in consultation with affected stakeholders, model language for purposes of the communication described in this subparagraph.

(C) The department shall seek any federal approvals it deems necessary to implement this paragraph. This paragraph shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and not otherwise jeopardized.

(D) This paragraph shall be effective on January 1, 2023, or on the effective date or dates reflected in the applicable federal approvals obtained by the department pursuant to subparagraph (C), whichever is later.

(E) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, and make specific this paragraph by means of all-county letters, plan letters, provider manuals, information notices, provider bulletins, and similar instructions, without taking any further regulatory action.

(F) Telehealth modalities authorized pursuant to this paragraph shall be subject to the billing, reimbursement, and utilization management policies imposed by the department.

(G) Services delivered via telehealth modalities described in this paragraph shall comply with the privacy and security requirements contained in the federal Health Insurance Portability and Accountability Act of 1996 found in Parts 160 and 164 of Title 45 of the Code of Federal Regulations, the Medicaid state plan, and any other applicable state and federal statutes and regulations.

(h) If FQHC or RHC services are partially reimbursed by a third-party payer, such as a managed care entity, as defined in Section 1396u-2(a)(1)(B) of Title 42 of the United States Code, the Medicare Program, or the Child Health and Disability Prevention (CHDP) Program, the department shall reimburse an FQHC or RHC for the difference between its per-visit PPS rate and receipts from other plans or programs on a contract-by-contract basis and not in the aggregate, and may not include managed care financial incentive payments that are required by federal law to be excluded from the calculation.

(i) (1) Provided that the following entities are not operating as intermittent clinics, as defined in subdivision (h) of Section 1206 of the Health and Safety Code, each entity shall have its reimbursement rate established in accordance with one of the methods outlined in paragraph (2) or (3), as selected by the FQHC or RHC:

(A) An entity that first qualifies as an FQHC or RHC in 2001 or later.

(B) A newly licensed facility at a new location added to an existing FQHC or RHC.

(C) An entity that is an existing FQHC or RHC that is relocated to a new site.

(2) (A) An FQHC or RHC that adds a new licensed location to its existing primary care license under paragraph (1) of subdivision (b) of Section 1212 of the Health and Safety Code may elect to have the reimbursement rate for the new location established in accordance with paragraph (3), or notwithstanding subdivision (e), an FQHC or RHC may choose to have one PPS rate for all locations that appear on its primary care license determined by submitting a change in scope of service request if both of the following requirements are met:

(i) The change in scope of service request includes the costs and visits for those locations for the first full fiscal year immediately following the date the new location is added to the FQHC's or RHC's existing licensee.

(ii) The FQHC or RHC submits the change in scope of service request within 90 days after the FQHC's or RHC's first full fiscal year.

(B) The FQHC's or RHC's single PPS rate for those locations shall be calculated based on the total costs and total visits of those locations and shall be determined based on the following:

(i) An audit in accordance with Section 14170.

(ii) Rate changes based on a change in scope of service request shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successors.

(iii) Any approved increase or decrease in the provider's rate shall be retroactive to the beginning of the FQHC's or RHC's fiscal year in which the request is submitted.

(C) Except as specified in subdivision (j), this paragraph does not apply to a location that was added to an existing primary care clinic license by the State Department of Public Health, whether by a regional district office or the centralized application unit, prior to January 1, 2017.

(3) If an FQHC or RHC does not elect to have the PPS rate determined by a change in scope of service request, the FQHC or RHC shall have the reimbursement rate established for any of the entities identified in paragraph (1) or (2) in accordance with one of the following methods at the election of the FQHC or RHC:

(A) The rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or adjacent area with a similar caseload.

(B) In the absence of three comparable FQHCs or RHCs with a similar caseload, the rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or an adjacent service area, or in a reasonably similar geographic area with respect to relevant social, health care, and economic characteristics.

(C) At a new entity's one-time election, the department shall establish a reimbursement rate, calculated on a per-visit basis, that is equal to 100 percent of the projected allowable costs to the FQHC or RHC of furnishing FQHC or RHC services during the first 12 months of operation as an FQHC or RHC. After the first 12-month period, the projected per-visit rate shall be increased by the Medicare Economic Index then in effect. The projected allowable costs for the first 12 months shall be cost settled and the prospective payment reimbursement rate shall be adjusted based on actual and allowable cost per visit.

(D) The department may adopt any further and additional methods of setting reimbursement rates for newly qualified FQHCs or RHCs as are consistent with Section 1396a(bb)(4) of Title 42 of the United States Code.

(4) In order for an FQHC or RHC to establish the comparability of its caseload for purposes of subparagraph (A) or (B) of paragraph (1), the department shall require that the FQHC or RHC submit its most recent annual utilization report as submitted to the Office of Statewide Health Planning and Development, unless the FQHC or RHC was not required to file an annual utilization report. FQHCs or RHCs that have experienced changes in their services or caseload subsequent to the filing of the annual utilization report may submit to the department a completed report in the format applicable to the prior calendar year. FQHCs or RHCs that have not previously

submitted an annual utilization report shall submit to the department a completed report in the format applicable to the prior calendar year. The FQHC or RHC shall not be required to submit the annual utilization report for the comparable FQHCs or RHCs to the department, but shall be required to identify the comparable FQHCs or RHCs.

(5) The rate for any newly qualified entity set forth under this subdivision shall be effective retroactively to the later of the date that the entity was first qualified by the applicable federal agency as an FQHC or RHC, the date a new facility at a new location was added to an existing FQHC or RHC, or the date on which an existing FQHC or RHC was relocated to a new site. The FQHC or RHC shall be permitted to continue billing for Medi-Cal covered benefits on a fee-for-service basis under its existing provider number until it is informed of its FQHC or RHC enrollment approval, and the department shall reconcile the difference between the fee-for-service payments and the FQHC's or RHC's prospective payment rate at that time.

(j) (1) Visits occurring at an intermittent clinic site, as defined in subdivision (h) of Section 1206 of the Health and Safety Code, of an existing FQHC or RHC, in a mobile unit as defined by paragraph (2) of subdivision (b) of Section 1765.105 of the Health and Safety Code, or at the election of the FQHC or RHC and subject to paragraph (2), a location added to an existing primary care clinic license by the State Department of Public Health prior to January 1, 2017, shall be billed by and reimbursed at the same rate as the FQHC or RHC that either established the intermittent clinic site or mobile unit, or that held the clinic license to which the location was added prior to January 1, 2017.

(2) If an FQHC or RHC with at least one additional location on its primary care clinic license that was added by the State Department of Public Health prior to January 1, 2017, applies for an adjustment to its per-visit rate based on a change in the scope of services provided by the FQHC or RHC as described in subdivision (e), all locations on the FQHC's or RHC's primary care clinic license shall be subject to a scope-of-service adjustment in accordance with either paragraph (2) or (3) of subdivision (i), as selected by the FQHC or RHC.

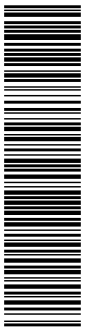
(3) This subdivision does not preclude or otherwise limit the right of the FQHC or RHC to request a scope-of-service adjustment to the rate.

(k) An FQHC or RHC may elect to have pharmacy or dental services reimbursed on a fee-for-service basis, utilizing the current fee schedules established for those services. These costs shall be adjusted out of the FQHC's or RHC's clinic base rate as scope-of-service changes. An FQHC or RHC that reverses its election under this subdivision shall revert to its prior rate, subject to an increase to account for all Medicare Economic Index increases occurring during the intervening time period, and subject to any increase or decrease associated with applicable scope-of-service adjustments as provided in subdivision (e).

(*l*) Reimbursement for Drug Medi-Cal services shall be provided pursuant to this subdivision.

(1) An FQHC or RHC may elect to have Drug Medi-Cal services reimbursed directly from a county or the department under contract with the FQHC or RHC pursuant to paragraph (4).

(2) (A) For an FQHC or RHC to receive reimbursement for Drug Medi-Cal services directly from the county or the department under contract with the FQHC or RHC pursuant to paragraph (4), costs associated with providing Drug Medi-Cal services



shall not be included in the FQHC's or RHC's per-visit PPS rate. For purposes of this subdivision, the costs associated with providing Drug Medi-Cal services shall not be considered to be within the FQHC's or RHC's clinic base PPS rate if in delivering Drug Medi-Cal services the clinic uses different clinical staff at a different location.

(B) If the FQHC or RHC does not use different clinical staff at a different location to deliver Drug Medi-Cal services, the FQHC or RHC shall submit documentation, in a manner determined by the department, that the current per-visit PPS rate does not include any costs related to rendering Drug Medi-Cal services, including costs related to utilizing space in part of the FQHC's or RHC's building, that are or were previously calculated as part of the clinic's base PPS rate.

(3) If the costs associated with providing Drug Medi-Cal services are within the FQHC's or RHC's clinic base PPS rate, as determined by the department, the Drug Medi-Cal services costs shall be adjusted out of the FQHC's or RHC's per-visit PPS rate as a change in scope of service.

(A) An FQHC or RHC shall submit to the department a scope-of-service change request to adjust the FQHC's or RHC's clinic base PPS rate after the first full fiscal year of rendering Drug Medi-Cal services outside of the PPS rate. Notwithstanding subdivision (e), the scope-of-service change request shall include a full fiscal year of activity that does not include Drug Medi-Cal services costs.

(B) An FQHC or RHC may submit requests for scope-of-service change under this subdivision only within 90 days following the beginning of the FQHC's or RHC's fiscal year. Any scope-of-service change request under this subdivision approved by the department shall be retroactive to the first day that Drug Medi-Cal services were rendered and reimbursement for Drug Medi-Cal services was received outside of the PPS rate, but in no case shall the effective date be earlier than January 1, 2018.

(C) The FQHC or RHC may bill for Drug Medi-Cal services outside of the PPS rate when the FQHC or RHC obtains approval as a Drug Medi-Cal provider and enters into a contract with a county or the department to provide these services pursuant to paragraph (4).

(D) Within 90 days of receipt of the request for a scope-of-service change under this subdivision, the department shall issue the FQHC or RHC an interim rate equal to 90 percent of the FQHC's or RHC's projected allowable cost, as determined by the department. An audit to determine the final rate shall be performed in accordance with Section 14170.

(E) Rate changes based on a request for scope-of-service change under this subdivision shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(F) For purposes of recalculating the PPS rate, the FQHC or RHC shall provide upon request to the department verifiable documentation as to which employees spent time, and the actual time spent, providing federally qualified health center services or rural health center services and Drug Medi-Cal services.

(G) After the department approves the adjustment to the FQHC's or RHC's clinic base PPS rate and the FQHC or RHC is approved as a Drug Medi-Cal provider, an FQHC or RHC shall not bill the PPS rate for any Drug Medi-Cal services provided pursuant to a contract entered into with a county or the department pursuant to paragraph (4).

(H) An FQHC or RHC that reverses its election under this subdivision shall revert to its prior PPS rate, subject to an increase to account for all Medicare Economic Index increases occurring during the intervening time period, and subject to any increase or decrease associated with the applicable scope-of-service adjustments as provided for in subdivision (e).

(4) Reimbursement for Drug Medi-Cal services shall be determined according to subparagraph (A) or (B), depending on whether the services are provided in a county that participates in the Drug Medi-Cal organized delivery system (DMC-ODS).

(A) In a county that participates in the DMC-ODS, the FQHC or RHC shall receive reimbursement pursuant to a mutually agreed upon contract entered into between the county or county designee and the FQHC or RHC. If the county or county designee refuses to contract with the FQHC or RHC, the FQHC or RHC may follow the contract denial process set forth in the Special Terms and Conditions.

(B) In a county that does not participate in the DMC-ODS, the FQHC or RHC shall receive reimbursement pursuant to a mutually agreed upon contract entered into between the county and the FQHC or RHC. If the county refuses to contract with the FQHC or RHC, the FQHC or RHC may request to contract directly with the department and shall be reimbursed for those services at the Drug Medi-Cal fee-for-service rate.

(5) The department shall not reimburse an FQHC or RHC pursuant to subdivision (h) for the difference between its per-visit PPS rate and any payments for Drug Medi-Cal services made pursuant to this subdivision.

(6) For purposes of this subdivision, the following definitions apply:

(A) "Drug Medi-Cal organized delivery system" or "DMC-ODS" means the Drug Medi-Cal organized delivery system authorized under the California Medi-Cal 2020 Demonstration, Number 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services and described in the Special Terms and Conditions.

(B) "Special Terms and Conditions" has the same meaning as set forth in subdivision (o) of Section 14184.10.

(m) Reimbursement for specialty mental health services shall be provided pursuant to this subdivision.

(1) An FQHC or RHC and one or more mental health plans that contract with the department pursuant to Section 14712 may mutually elect to enter into a contract to have the FQHC or RHC provide specialty mental health services to Medi-Cal beneficiaries as part of the mental health plan's network.

(2) (A) For an FQHC or RHC to receive reimbursement for specialty mental health services pursuant to a contract entered into with the mental health plan under paragraph (1), the costs associated with providing specialty mental health services shall not be included in the FQHC's or RHC's per-visit PPS rate. For purposes of this subdivision, the costs associated with providing specialty mental health services shall not be considered to be within the FQHC's or RHC's clinic base PPS rate if in delivering specialty mental health services the clinic uses different clinical staff at a different location.

(B) If the FQHC or RHC does not use different clinical staff at a different location to deliver specialty mental health services, the FQHC or RHC shall submit documentation, in a manner determined by the department, that the current per-visit PPS rate does not include any costs related to rendering specialty mental health services,

including costs related to utilizing space in part of the FQHC's or RHC's building, that are or were previously calculated as part of the clinic's base PPS rate.

(3) If the costs associated with providing specialty mental health services are within the FQHC's or RHC's clinic base PPS rate, as determined by the department, the specialty mental health services costs shall be adjusted out of the FQHC's or RHC's per-visit PPS rate as a change in scope of service.

(A) An FQHC or RHC shall submit to the department a scope-of-service change request to adjust the FQHC's or RHC's clinic base PPS rate after the first full fiscal year of rendering specialty mental health services outside of the PPS rate. Notwithstanding subdivision (e), the scope-of-service change request shall include a full fiscal year of activity that does not include specialty mental health costs.

(B) An FQHC or RHC may submit requests for a scope-of-service change under this subdivision only within 90 days following the beginning of the FQHC's or RHC's fiscal year. Any scope-of-service change request under this subdivision approved by the department is retroactive to the first day that specialty mental health services were rendered and reimbursement for specialty mental health services was received outside of the PPS rate, but the effective date shall not be earlier than January 1, 2018.

(C) The FQHC or RHC may bill for specialty mental health services outside of the PPS rate when the FQHC or RHC contracts with a mental health plan to provide these services pursuant to paragraph (1).

(D) Within 90 days of receipt of the request for a scope-of-service change under this subdivision, the department shall issue the FQHC or RHC an interim rate equal to 90 percent of the FQHC's or RHC's projected allowable cost, as determined by the department. An audit to determine the final rate shall be performed in accordance with Section 14170.

(E) Rate changes based on a request for scope-of-service change under this subdivision shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(F) For the purpose of recalculating the PPS rate, the FQHC or RHC shall provide upon request to the department verifiable documentation as to which employees spent time, and the actual time spent, providing federally qualified health center services or rural health center services and specialty mental health services.

(G) After the department approves the adjustment to the FQHC's or RHC's clinic base PPS rate, an FQHC or RHC shall not bill the PPS rate for any specialty mental health services that are provided pursuant to a contract entered into with a mental health plan pursuant to paragraph (1).

(H) An FQHC or RHC that reverses its election under this subdivision shall revert to its prior PPS rate, subject to an increase to account for all Medicare Economic Index increases occurring during the intervening time period, and subject to any increase or decrease associated with the applicable scope-of-service adjustments as provided for in subdivision (e).

(4) The department shall not reimburse an FQHC or RHC pursuant to subdivision (h) for the difference between its per-visit PPS rate and any payments made for specialty mental health services under this subdivision.

(n) FQHCs and RHCs may appeal a grievance or complaint concerning ratesetting, scope-of-service changes, and settlement of cost report audits, in the manner

prescribed by Section 14171. The rights and remedies provided under this subdivision are cumulative to the rights and remedies available under all other provisions of law of this state.

(o) The department shall promptly seek all necessary federal approvals in order to implement this section, including any amendments to the state plan. To the extent that any element or requirement of this section is not approved, the department shall submit a request to the federal Centers for Medicare and Medicaid Services for any waivers that would be necessary to implement this section.

(p) The department shall implement this section only to the extent that federal financial participation is available.

(q) Notwithstanding any other law, the director may, without taking regulatory action pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, implement, interpret, or make specific subdivisions (*l*) and (m) by means of a provider bulletin or similar instruction. The department shall notify and consult with interested parties and appropriate stakeholders in implementing, interpreting, or making specific the provisions of subdivisions (*l*) and (m), including all of the following:

(1) Notifying provider representatives in writing of the proposed action or change. The notice shall occur, and the applicable draft provider bulletin or similar instruction, shall be made available at least 10 business days prior to the meeting described in paragraph (2).

(2) Scheduling at least one meeting with interested parties and appropriate stakeholders to discuss the proposed action or change.

(3) Allowing for written input regarding the proposed action or change, to which the department shall provide summary written responses in conjunction with the issuance of the applicable final written provider bulletin or similar instruction.

(4) Providing at least 60 days advance notice of the effective date of the proposed action or change.

SEC. 2. Section 14132.725 of the Welfare and Institutions Code is repealed.

~~14132.725. (a) To the extent that federal financial participation is available, face-to-face contact between a health care provider and a patient is not required under the Medi-Cal program for health care services provided by asynchronous store and forward, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code. Services appropriately provided through the store and forward process are subject to billing and reimbursement policies developed by the department.~~

~~(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, and make specific this section by means of all-county letters, provider bulletins, and similar instructions.~~

SEC. 3. Section 14132.725 is added to the Welfare and Institutions Code, to read:

14132.725. (a) For purposes of this section, the following definitions apply:

(1) "Border community" means border areas adjacent to the State of California where it is customary practice for California residents to use medical resources in adjacent areas outside the state. Under these circumstances, program controls and limitations are the same as for services rendered by health care providers within the state.

(2) "Health care provider" has the same meaning as set forth in paragraph (3) of subdivision (a) of Section 2290.5 of the Business and Professions Code, and shall be either enrolled as a Medi-Cal rendering provider, or a nonphysician medical practitioner affiliated with an enrolled Medi-Cal provider group. The enrolled Medi-Cal provider or provider group for which the health care provider renders services via telehealth shall meet all Medi-Cal requirements and shall be located in the state or a border community.

(3) "Health care service plan" has the same meaning as set forth in subdivision (f) of Section 1345 of the Health and Safety Code.

(4) "Medi-Cal managed care plan" has the same meaning as set forth in subdivision (j) of Section 14184.101.

(5) "Network provider" has the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

(6) "Telehealth" has the same meaning as set forth in paragraph (6) of subdivision (a) of Section 2290.5 of the Business and Professions Code.

(b) (1) Subject to subdivision (j), in-person, face-to-face contact between a health care provider and a patient is not required under the Medi-Cal program for covered health care services and provider types designated by the department, when provided by video synchronous interaction, asynchronous store and forward, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities, when those services and settings meet the applicable standard of care and meet the requirements of the service code being billed.

(2) (A) In implementing this section, the department shall designate and periodically update the covered health care services and provider types, including required licensing and credentialing criteria, as applicable, which may be appropriately delivered via the telehealth modalities described in this subdivision.

(B) Applicable health care services appropriately provided through video synchronous interaction, asynchronous store and forward, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities are subject to billing, reimbursement, and utilization management policies imposed by the department. Subject to subdivision (j), utilization management protocols adopted by the department pursuant to this section shall be consistent with, and no more restrictive than, those authorized for health care service plans pursuant to Section 1374.13 of the Health and Safety Code.

(c) (1) Pursuant to an effective date designated by the department that is no sooner than January 1, 2024, a Medi-Cal provider furnishing applicable health care services via audio-only synchronous interaction shall also offer those same health care services via video synchronous interaction to preserve beneficiary choice.

(2) Effective on the date designated by the department pursuant to paragraph (1), a provider furnishing services through video synchronous interaction or audio-only synchronous interaction shall also do one of the following:

(A) Offer those services via in-person, face-to-face contact.

(B) Arrange for a referral to, and a facilitation of, in-person care that does not require a patient to independently contact a different provider to arrange for that care.

(3) In implementing this subdivision, the department shall consider additional recommendations from affected stakeholders regarding the need to maintain access to in-person services without unduly restricting access to telehealth services.

(4) A health care provider may establish a new patient relationship with a Medi-Cal beneficiary via video synchronous interaction consistent with any requirements imposed by the department.

(5) A health care provider shall not establish a new patient relationship with a Medi-Cal beneficiary via asynchronous store and forward, telephonic (audio-only) synchronous interaction, remote patient monitoring, or other virtual communication modalities, except as set forth in paragraph (4) of subdivision (g) of Section 14132.100. Notwithstanding this prohibition, the department may provide for specific exceptions to this prohibition, which shall be developed in consultation with affected stakeholders and published in departmental guidance.

(6) Subject to subdivision (j), the department may establish separate fee schedules for applicable health care services delivered via remote patient monitoring or other permissible virtual communication modalities.

(d) In addition to any existing law requiring beneficiary consent to telehealth, including, but not limited to, subdivision (b) of Section 2290.5 of the Business and Professions Code, all of the following shall be communicated by a health care provider to a Medi-Cal beneficiary, in writing or verbally, at least once prior to initiating the delivery of applicable health care services via telehealth to a Medi-Cal beneficiary: an explanation that beneficiaries have the right to access covered services that may be delivered via telehealth through an in-person, face-to-face visit; an explanation that use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time by the Medi-Cal beneficiary without affecting their ability to access covered Medi-Cal services in the future; an explanation of the availability of Medi-Cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted; and the potential limitations or risks related to receiving services through telehealth as compared to an in-person visit, to the extent any limitations or risks are identified by the provider.

(1) The provider shall document in the patient record the provision of this information and the patient's verbal or written acknowledgment that the information was received.

(2) The department shall develop, in consultation with affected stakeholders, model language for purposes of the communication described in this subdivision.

(e) (1) The department shall develop, in consultation with affected stakeholders, an informational notice to be distributed to fee-for-service Medi-Cal beneficiaries and for use by Medi-Cal managed care plans in communicating to their enrollees. Information in the notice shall include, but not be limited to, all of the following:

(A) The availability of Medi-Cal covered telehealth services.

(B) The beneficiary's right to access all medically necessary covered services through in-person, face-to-face visits, and a provider's and Medi-Cal managed care plan's responsibility to offer or arrange for that in-person care, as applicable.

(C) An explanation that use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn by the Medi-Cal beneficiary at any time without affecting their ability to access covered Medi-Cal services in the future.

(D) An explanation of the availability of Medi-Cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted.

(E) Notification of the beneficiary's right to make complaints about the offer of telehealth services in lieu of in-person care or about the quality of care delivered through telehealth.

(2) The informational notice shall be translated into threshold languages determined by the department pursuant to subdivision (b) of Section 14029.91 and provided in a format that is culturally and linguistically appropriate.

(f) (1) Subject to subdivision (j), the department shall reimburse health care providers of applicable health care services delivered via video synchronous interaction or synchronous audio-only modality at payment amounts that are not less than the amounts the provider would receive if the services were delivered via in-person, face-to-face contact, so long as the services or settings meet the applicable standard of care and meet the requirements of the service code being billed.

(2) Subject to subdivision (j), for applicable health care services appropriately provided by a network provider via video synchronous interaction or an audio-only synchronous interaction modality to an enrollee of a Medi-Cal managed care plan, the Medi-Cal managed care plan shall reimburse the network provider at payment amounts that are not less than the amounts the network provider would have received if the services were delivered via in-person, face-to-face contact, unless the Medi-Cal managed care plan and network provider mutually agree to reimbursement in different amounts.

(g) On or before January 1, 2023, the department shall develop a research and evaluation plan that does all of the following:

(1) Proposes strategies to analyze the relationship between telehealth and the following: access to care, access to in-person care, quality of care, and Medi-Cal program costs, utilization, and program integrity.

(2) Examines issues using an equity framework that includes stratification by available geographic and demographic factors, including, but not limited to, race, ethnicity, primary language, age, and gender, to understand inequities and disparities in care.

(3) Prioritizes research and evaluation questions that directly inform Medi-Cal policy.

(h) Applicable health care services provided through asynchronous store and forward, video synchronous interaction, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities as described in this section shall comply with the privacy and security requirements contained in the federal Health Insurance Portability and Accountability Act of 1996 found in Parts 160 and 164 of Title 45 of the Code of Federal Regulations, the Medicaid State Plan, and any other applicable state and federal statutes and regulations.

(i) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, and make specific this section by means of all-county letters, plan letters, provider bulletins, and similar instructions, without taking any further regulatory action.

(j) The department shall seek any federal approvals it deems necessary to implement this section. This section shall be implemented only to the extent that any

necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(k) This section shall be effective on January 1, 2023, or on the effective date or dates reflected in the applicable federal approvals obtained by the department pursuant to subdivision (j), whichever is later.

SEC. 4. Section 14132.731 of the Welfare and Institutions Code is repealed.

~~14132.731. (a) A Drug Medi-Cal certified provider shall receive reimbursement for individual counseling services provided through telehealth, as defined in Section 2290.5 of the Business and Professions Code, by a licensed practitioner of the healing arts or a registered or certified alcohol or other drug counselor, when medically necessary and in accordance with the Medicaid state plan.~~

~~(b) This section shall be implemented only to the extent federal financial participation is available and only if any necessary federal approvals have been obtained.~~

~~(c) The department shall adopt regulations by July 1, 2022, to implement this section in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).~~

~~(d) Notwithstanding the rulemaking provisions of the Administrative Procedure Act, the department may, if it deems it appropriate, implement, interpret, or make specific this section by means of provider bulletins, written guidelines, or similar instructions from the department, until regulations are adopted.~~

SEC. 5. Section 14132.731 is added to the Welfare and Institutions Code, to read:

14132.731. (a) A county that enters into a Drug Medi-Cal Treatment Program contract with the department in accordance with Section 14124.20, or the department if entering into a Drug Medi-Cal Treatment Program contract directly with providers or as otherwise described in Section 14124.21, shall reimburse Drug Medi-Cal certified providers for medically necessary Drug Medi-Cal reimbursable services, as defined in Section 14124.24, provided by a licensed practitioner of the healing arts, or a registered or certified alcohol or other drug counselor or other individual authorized by the department to provide Drug Medi-Cal reimbursable services when those services meet the standard of care, meet the requirements of the service code being billed, and are delivered through video synchronous interaction or audio-only synchronous interaction.

(b) A Drug Medi-Cal certified provider may not establish a new patient relationship with a Medi-Cal beneficiary via asynchronous store and forward, audio-only synchronous interaction, remote patient monitoring, or other virtual communication modalities, except as set forth in paragraph (4) of subdivision (g) of Section 14132.100. Notwithstanding this prohibition, the department may provide for specific exceptions to this prohibition, which shall be developed in consultation with affected stakeholders and published in departmental guidance.

(c) Drug Medi-Cal reimbursable services provided through a video synchronous interaction or an audio-only synchronous interaction pursuant to subdivision (a) shall be subject to billing, reimbursement, and utilization management policies imposed by the department.

(d) Drug Medi-Cal reimbursable services provided through a video synchronous interaction or an audio-only synchronous interaction shall be provided in compliance with the privacy and security requirements contained in the federal Health Insurance

Portability and Accountability Act of 1996 found in Parts 160 and 164 of Title 45 of the Code of Federal Regulations, Part 2 of Title 42 of the Code of Federal Regulations, the Medicaid State Plan, and any other applicable state and federal statutes and regulations.

(e) This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available.

(f) The department shall adopt regulations by July 1, 2024, to implement this section in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(g) Notwithstanding the rulemaking provisions of the Administrative Procedure Act, the department may, if it deems it appropriate, implement, interpret, or make specific this section by means of provider bulletins, written guidelines, or similar instructions from the department, until regulations are adopted.

SEC. 6. Section 14197 of the Welfare and Institutions Code is amended to read:

14197. (a) It is the intent of the Legislature that the department implement and monitor compliance with the time ~~and~~ or distance requirements set forth in Sections 438.68, 438.206, and 438.207 of Title 42 of the Code of Federal Regulations and this section, to ensure that all Medi-Cal managed care covered services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, as those standards were enacted in May 2016.

(b) Commencing January 1, 2018, for covered benefits under its contract, as applicable, a Medi-Cal managed care plan shall maintain a network of providers that are located within the following time ~~and~~ or distance standards for the following services:

(1) For primary care, both adult and pediatric, 10 miles or 30 minutes from the beneficiary's place of residence.

(2) For hospitals, 15 miles or 30 minutes from the beneficiary's place of residence.

(3) For dental services provided by a Medi-Cal managed care plan, 10 miles or 30 minutes from the beneficiary's place of residence.

(4) For obstetrics and gynecology primary care, 10 miles or 30 minutes from the beneficiary's place of residence.

(c) Commencing July 1, 2018, for the covered benefits under its contracts, as applicable, a Medi-Cal managed care plan shall maintain a network of providers that are located within the following time ~~and~~ or distance standards for the following services:

(1) For specialists, as defined in subdivision ~~(h),~~ (i), adult and pediatric, including obstetric and gynecology specialty care, as follows:

(A) Up to 15 miles or 30 minutes from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.

(B) Up to 30 miles or 60 minutes from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

(C) Up to 45 miles or 75 minutes from the beneficiary's place of residence for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.

(D) Up to 60 miles or 90 minutes from the beneficiary's place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

(2) For pharmacy services, 10 miles or 30 minutes from the beneficiary's place of residence.

(3) For outpatient mental health services, as follows:

(A) Up to 15 miles or 30 minutes from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.

(B) Up to 30 miles or 60 minutes from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

(C) Up to 45 miles or 75 minutes from the beneficiary's place of residence for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.

(D) Up to 60 miles or 90 minutes from the beneficiary's place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

(4) (A) For outpatient substance use disorder services other than opioid treatment programs, as follows:

(i) Up to 15 miles or 30 minutes from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.

(ii) Up to 30 miles or 60 minutes from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

(iii) Up to 60 miles or 90 minutes from the beneficiary's place of residence for the following counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Merced, Modoc, Monterey, Mono, Napa, Nevada, Plumas, San Benito, San Bernardino, San Luis Obispo, Santa Barbara, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, and Yuba.

(B) For opioid treatment programs, as follows:

(i) Up to 15 miles or 30 minutes from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.

(ii) Up to 30 miles or 60 minutes from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

(iii) Up to 45 miles or 75 minutes from the beneficiary's place of residence for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.

(iv) Up to 60 miles or 90 minutes from the beneficiary's place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

(d) (1) (A) A Medi-Cal managed care plan shall comply with the appointment time standards developed pursuant to Section 1367.03 of the Health and Safety Code, Section 1300.67.2.2 of Title 28 of the California Code of Regulations, subject to any authorized exceptions in Section 1300.67.2.2 of Title 28 of the California Code of Regulations, and the standards set forth in contracts entered into between the department and Medi-Cal managed care plans.

(B) Commencing July 1, 2018, subparagraph (A) applies to Medi-Cal managed care plans that are not, as of January 1, 2018, subject to the appointment time standards described in subparagraph (A).

(2) A Medi-Cal managed care plan shall comply with the following availability standards for skilled nursing facility services and intermediate care facility services, as follows:

(A) Within five business days of the request for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.

(B) Within seven business days of the request for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

(C) Within 14 calendar days of the request for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.

(D) Within 14 calendar days of the request for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

(3) A county Drug Medi-Cal organized delivery system shall provide an appointment within three business days to an opioid treatment program.

(4) A dental managed care plan shall provide an appointment within four weeks of a request for routine pediatric dental services and within 30 calendar days of a request for specialist pediatric dental services.

(e) The department may authorize a Medi-Cal managed care plan to use clinically appropriate video synchronous interaction, as defined in paragraph (5) of subdivision (a) of Section 2290.5 of the Business and Professions Code, as a means of demonstrating compliance with the time or distance standards established pursuant to this section, as defined by the department.

(f) (1) The department may develop policies for granting credit in the determination of compliance with time or distance standards established pursuant to this section when Medi-Cal managed care plans contract with specified providers to use clinically appropriate video synchronous interaction, as defined in paragraph (5) of subdivision (a) of Section 2290.5 of the Business and Professions Code.

~~(e) (1)~~

(2) The department, upon request of a Medi-Cal managed care plan, may authorize alternative access standards for the time ~~and~~ or distance standards established under this section if either of the following occur:

(A) The requesting Medi-Cal managed care plan has exhausted all other reasonable options to obtain providers to meet the applicable standard.

(B) The department determines that the requesting Medi-Cal managed care plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.

~~(2)~~

(3) (A) If a Medi-Cal managed care plan cannot meet the time ~~and~~ or distance standards set forth in this section, the Medi-Cal managed care plan shall submit a request for alternative access standards to the department, in the form and manner specified by the department. ~~A~~

(B) An alternative access standard request may be submitted at the same time as the Medi-Cal managed care plan submits its annual demonstration of compliance with time ~~and~~ or distance standards, if known at that ~~time.~~ time and at any time the Medi-Cal managed care plan is unable to meet time or distance standards.

(C) A Medi-Cal managed care plan is not required to submit a previously approved alternative access standard request to the department for review and approval on an annual basis, unless the Medi-Cal managed care plan requires modifications to its previously approved request. However, the Medi-Cal managed care plan shall submit this previously approved alternative access standard request to the department at least every three years for review and approval when the plan is required to demonstrate compliance with time or distance standards.

(D) A Medi-Cal managed care plan shall close out any corrective action plan deficiencies in a timely manner to ensure beneficiary access is adequate and shall continually work to improve access in its provider network.

~~(3)~~

(4) A request for alternative access standards shall be approved or denied on a ZIP Code and provider type, including specialty type, basis by the department within 90 days of submission of the request. The Medi-Cal managed care plan shall also include a description of the reasons justifying the alternative access standards based on those facts and circumstances. Effective no sooner than contract periods commencing on or after July 1, 2020, the Medi-Cal managed care plan shall include a description on how the Medi-Cal managed care plan intends to arrange for beneficiaries to access covered services if the health care provider is located outside of the time ~~and~~ or distance standards specified in subdivision (c). The department may stop the 90-day timeframe, on one or more occasions as necessary, in the event of an incomplete submission or to obtain additional information from the Medi-Cal managed care plan requesting the alternative access standards. Upon submission of sufficient additional information to the department, the 90-day timeframe shall resume at the same point in time it was previously stopped, except if there is less than 30 days remaining in which case the department shall approve or deny the request within 30 days of submission of sufficient additional information. If the department rejects the Medi-Cal managed care plan's proposal, the department shall inform the Medi-Cal managed care plan of the department's reason for rejecting the proposal. The department shall post any approved alternative access standards on its internet website.

~~(4) The department may authorize a Medi-Cal managed care plan to use clinically appropriate telecommunications technology as a means of determining annual compliance with the time and distance standards established pursuant to this section or may approve alternative access to care, including telehealth consistent with the requirements of Section 2290.5 of the Business and Professions Code, e-visits, or other evolving and innovative technological solutions that are used to provide care from a distance.~~

(5) As part of the department's evaluation of a request submitted by a Medi-Cal managed care plan to utilize an alternative access standard pursuant to this subdivision, the department shall evaluate and determine whether the resulting time ~~and~~ or distance is reasonable to expect a beneficiary to travel to receive care.

(6) The department may authorize a Medi-Cal managed care plan to use clinically appropriate video synchronous interaction, as defined in paragraph (5) of subdivision (a) of Section 2290.5 of the Business and Professions Code, as part of an alternative access standard request.

~~(f)~~

(g) (1) Effective for contract periods commencing on or after July 1, 2018, a Medi-Cal managed care plan shall, on an annual basis and when requested by the department, demonstrate to the department the Medi-Cal managed care plan's compliance with the time ~~and~~ or distance and appointment time standards developed pursuant to this section. The report shall measure compliance separately for adult and pediatric services for primary care, behavioral health, and core specialist services.

(2) Effective for contract periods commencing on or after July 1, 2020, the Medi-Cal managed care plan shall demonstrate, on an annual basis, and when requested by the department, to the department how the Medi-Cal managed care plan arranged for the delivery of Medi-Cal covered services to Medi-Cal enrollees, such as through the use of either Medi-Cal covered transportation or clinically appropriate ~~telecommunications technology, as specified in paragraph (4) of subdivision (e),~~ video synchronous interaction, as specified in paragraph (6) of subdivision (f), if the enrollees of a Medi-Cal managed care plan needed to obtain health care services from a health care provider or a facility located outside of the time ~~and~~ or distance standards, as specified in subdivision (c).

The report shall measure compliance separately for adult and pediatric services for primary care, behavioral health, and core specialist services.

(3) Effective for contract periods commencing on or after July 1, 2018, the department shall evaluate on an annual basis a Medi-Cal managed care plan's compliance with the time ~~and~~ or distance and appointment time standards implemented pursuant to this section. This evaluation may include, but need not be limited to, annual and random surveys, investigation of complaints, grievances, or other indicia of noncompliance. Nothing in this subdivision shall be construed to limit the appeal rights of a Medi-Cal managed care plan under its contracts with the department.

(4) The department shall publish annually on its internet website a report that details the department's findings in evaluating a Medi-Cal managed care plan's compliance under paragraph (2). At a minimum, the department shall specify in this report those Medi-Cal managed care plans, if any, that were subject to a corrective action plan due to noncompliance with the time ~~and~~ or distance and appointment time standards implemented pursuant to this section during the applicable year and the basis

for the department's finding of noncompliance. The report shall include a Medi-Cal managed care plan's response to the corrective plan, if available.

~~(g)~~

(h) The department shall consult with Medi-Cal managed care plans, including dental managed care plans, mental health plans, and Drug Medi-Cal Organized Delivery System programs, health care providers, consumers, providers and consumers of long-term services and supports, and organizations representing Medi-Cal beneficiaries in the implementation of the requirements of this section.

~~(h)~~

(i) For purposes of this section, the following definitions apply:

(1) "Medi-Cal managed care plan" means any individual, organization, or entity that enters into a contract with the department to provide services to enrolled Medi-Cal beneficiaries pursuant to any of the following:

(A) Article 2.7 (commencing with Section 14087.3), including dental managed care programs developed pursuant to Section 14087.46.

(B) Article 2.8 (commencing with Section 14087.5).

(C) Article 2.81 (commencing with Section 14087.96).

(D) Article 2.82 (commencing with Section 14087.98).

(E) Article 2.9 (commencing with Section 14088).

(F) Article 2.91 (commencing with Section 14089).

(G) Chapter 8 (commencing with Section 14200), including dental managed care plans.

(H) Chapter 8.9 (commencing with Section 14700).

(I) A county Drug Medi-Cal organized delivery system authorized under the California Medi-Cal 2020 Demonstration pursuant to Article 5.5 (commencing with Section 14184) or a successor demonstration or waiver, as applicable.

(2) "Specialist" means any of the following:

(A) Cardiology/interventional cardiology.

(B) Nephrology.

(C) Dermatology.

(D) Neurology.

(E) Endocrinology.

(F) Ophthalmology.

(G) Ear, nose, and throat/otolaryngology.

(H) Orthopedic surgery.

(I) Gastroenterology.

(J) Physical medicine and rehabilitation.

(K) General surgery.

(L) Psychiatry.

(M) Hematology.

(N) Oncology.

(O) Pulmonology.

(P) HIV/AIDS specialists/infectious diseases.

~~(i)~~

(j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, may implement, interpret, or make specific this section by

means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted.

~~(j)~~

(k) The department shall seek any federal approvals it deems necessary to implement this section. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

~~(k)~~

(*l*) This section shall remain in effect only until January 1, ~~2023,~~ 2026, and as of that date is repealed, unless a later enacted statute that is enacted before January 1, ~~2023,~~ 2026, deletes or extends that date.

SEC. 7. Section 14197.04 of the Welfare and Institutions Code is amended to read:

14197.04. (a) (1) A Medi-Cal managed care plan that has received approval from the department to utilize an alternative access standard pursuant to subdivision ~~(e)~~ (f) of Section 14197, upon the request of an enrollee who is required to travel farther than the time ~~and~~ or distance standards, as established in subdivision (c) of Section 14197, shall assist that enrollee in obtaining an appointment with an appropriate specialist provider within the time ~~and~~ or distance standards established pursuant to subdivision (c) of Section 14197 and the appointment time standards established pursuant to subdivision (d) of Section 14197.

(2) For purposes of complying with the requirement to assist an enrollee, as specified in paragraph (1), a Medi-Cal managed care plan shall do either of the following:

(A) Make its best effort to establish a member-specific case agreement, at the Medi-Cal fee-for-service rate or a rate mutually agreed upon by the specialist provider and the plan, with an appropriate specialist provider within the time ~~and~~ or distance standards established pursuant to subdivision (c) of Section 14197 and the appointment time standards established pursuant to subdivision (d) of Section 14197.

(B) Arrange for an appointment with a network specialist provider within the time ~~and~~ or distance standards established pursuant to subdivision (c) of Section 14197, and the appointment time standards established pursuant to subdivision (d) of Section 14197.

(3) The requirements of paragraph (1) shall not apply if there is not a specialist provider with an office location within the applicable time ~~and~~ or distance standards in relation to the area within which the enrollee resides or the Medi-Cal managed care plan has attempted to establish a member-specific case agreement with the specialist provider for any enrollee pursuant to subparagraph (A) of paragraph (2) in the most recent fiscal year and the provider refused to enter into a member-specific case agreement.

(b) If a specialist provider is unavailable to render necessary health care services pursuant to subdivision (a) to an enrollee within the time ~~and~~ or distance standards established pursuant to subdivision (c) of Section 14197 and the appointment time standards established pursuant to subdivision (d) of Section 14197, as specified in subdivision (a), the Medi-Cal managed care plan or the Medi-Cal fee-for-service program, as determined appropriate by the department, shall arrange for Medi-Cal

covered transportation for an enrollee to obtain covered Medi-Cal services pursuant to Section 14132.

(c) A Medi-Cal managed care plan that has received approval from the department to utilize an alternative access standard pursuant to subdivision ~~(e)~~ (f) of Section 14197 shall inform its affected members of the approved alternative access standards in a manner and timeframe, as determined by the department.

(d) (1) "Medi-Cal managed care plan" means any individual, organization, or entity that enters into a contract with the department to provide services to enrolled Medi-Cal beneficiaries pursuant to any of the following:

(A) Article 2.7 (commencing with Section 14087.3), including dental managed care programs developed pursuant to Section 14087.46.

(B) Article 2.8 (commencing with Section 14087.5).

(C) Article 2.81 (commencing with Section 14087.96).

(D) Article 2.82 (commencing with Section 14087.98).

(E) Article 2.91 (commencing with Section 14089).

(F) Chapter 8 (commencing with Section 14200), including dental managed care plans.

(G) Chapter 8.9 (commencing with Section 14700).

(H) A county Drug Medi-Cal organized delivery system authorized under the California Medi-Cal 2020 Demonstration pursuant to Article 5.5 (commencing with Section 14184) or a successor demonstration or waiver, as applicable.

(2) "Specialist provider" has the same meaning as "specialist" as defined in paragraph (2) of subdivision ~~(h)~~ (i) of Section 14197.

LEGISLATIVE COUNSEL'S DIGEST

Bill No.
as introduced, _____.
General Subject: Medi-Cal: telehealth.

(1) Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, face-to-face contact between a health care provider and a patient is not required under the Medi-Cal program for health care services provided by the modality of asynchronous store and forward, as defined, to the extent that federal financial participation is available.

This bill would also provide that face-to-face contact is not required when covered health care services are provided by video synchronous interaction, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities, when those services and settings meet certain criteria. The bill would require a provider furnishing services through video synchronous interaction or audio-only synchronous interaction to also offer those services through in-person, face-to-face contact or arrange for a referral to in-person care, as specified. The bill would authorize a provider to establish a new patient relationship with a Medi-Cal beneficiary through video synchronous interaction, and would prohibit a provider from doing so through the other modalities, except as specified.

The bill would set forth other requirements on the department or a Medi-Cal provider relating to the use of those telehealth modalities, including requirements concerning fee schedules and minimum reimbursement limits, services in border communities, as defined, consent standards, privacy and security compliance, informational notices, and a research and evaluation plan.

(2) Under existing law, federally qualified health center (FQHC) services and rural health clinic (RHC) services are covered benefits under the Medi-Cal program, to be reimbursed, to the extent that federal financial participation is available, to providers on a per-visit basis. "Visit" is defined as a face-to-face encounter between an FQHC or RHC patient and any of specified health care professionals.

This bill would expand "visit" to include an encounter between an FQHC or RHC patient and any of specified health care professionals using video or audio-only synchronous interaction when the applicable standard of care and other conditions are met. The bill would set forth other requirements on an FQHC or RHC relating to the use of those telehealth modalities, including requirements concerning reimbursement rates, consent standards, privacy and security compliance, the establishment of new patient relationships, and in-person services or referrals.

(3) Existing law establishes the Drug Medi-Cal Treatment Program (Drug Medi-Cal), under which the department is authorized to enter into contracts with each county, or enter into contracts directly with certified providers, for the provision of various alcohol and drug use treatment services to Medi-Cal beneficiaries. Existing

law requires, to the extent federal financial participation is available and any necessary federal approvals have been obtained, that a Drug Medi-Cal certified provider receive reimbursement for individual counseling services provided through telehealth by a licensed practitioner of the healing arts or a registered or certified alcohol or other drug counselor, when medically necessary and in accordance with the Medicaid state plan.

This bill would expand reimbursement for other medically necessary Drug Medi-Cal services and to other authorized individuals when those services are delivered through video synchronous interaction or audio-only synchronous interaction. The bill would similarly set forth certain requirements relating to privacy and security compliance and the establishment of new patient relationships through telehealth modalities. The bill would require the department to adopt regulations by July 1, 2024, to implement these provisions.

(4) Existing law establishes, until January 1, 2023, certain time and distance and appointment time standards for specified services to ensure that Medi-Cal managed care covered services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner.

This bill would extend those provisions to January 1, 2026.

Existing law authorizes the department to allow a Medi-Cal managed care plan to use clinically appropriate telecommunications technology as a means of determining annual compliance with the time and distance standards or to approve alternative access to care, including telehealth, e-visits, or other evolving and innovative technological solutions that are used to provide care from a distance.

This bill would instead authorize the department to allow a Medi-Cal managed care plan to use clinically appropriate video synchronous interaction as a means of demonstrating compliance with the time or distance standards, and as part of an alternative access standard request. The bill would authorize the department to develop policies for granting credit, as specified.

If a Medi-Cal managed care plan cannot meet the time and distance standards, existing law requires the plan to submit a request for alternative access standards to the department, as specified.

This bill would make changes to the frequency of those request submissions. The bill would also require the plan to close out any corrective action plan deficiencies in a timely manner to ensure beneficiary access is adequate and to continually work to improve access in its provider network.

The bill would set forth other requirements on the department and would make conforming changes to related provisions.

(5) This bill would condition implementation of the above-described provisions on receipt of any necessary federal approvals and the availability of federal financial participation.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.